Dilatation of the Heart as the Cause of Cardiac Hæmic Murmurs.

Dr. G. W. **Balfour** has been led to adopt the theory of dilatation of the heart as the cause of cardiac, hæmic, or chlorotic murmurs, because it seems to be the only one capable of reconciling the various discrepant hypotheses regarding the origin of these murmurs.

This theory is fraught with most important instruction on the one hand, and with no less momentous warning on the other; because, if it be true, there is no longer any real distinction between functional and organic murmurs; and a murmur can only be looked upon as functional when it is found to have been curable. Moreover, if functional murmurs are really due to dilatation, as these murmurs are known to disappear—to become cured—in by far the larger number of cases, we thus obtain the important generalization that dilatation of the heart is a curable disease. The curability of such affections becomes merely a question of degree; they are more or less curable, according to the length of time they have persisted, and the extent to which the dilatation has progressed. This is the lesson with which this theory is fraught, and it involves the warning; because, if so-called functional murmurs are due to dilatation, and dilatation becomes incurable by persistence and extension, it is surely a most important matter that we should all take care that none of our cases of functional disease become organic by neglect.

Dr. Balfour has adopted the theory of cardiac dilatation as the cause of cardiac hæmic murmurs for three reasons: first, because it alone is capable of explaining rationally all the discrepancies in the prevalent theories of these murmurs; second, because it is thoroughly consistent with the results obtained by experiment; and third, because it is perfectly consonant with clinical experience.—*Brit. Med. Journal*, Aug. 26, 1882.

Syphilitic Myocarditis.

Dr. **Mannino**, of Palermo, reports the following case, in which syphilitic disease of the heart was diagnosed during life (*Giorn. Ital. delle Mal. Ven. e della Pelle*, Dec. 1881). A man, aged 36, was admitted into hospital, under the care of Dr. Federici, on Feb. 15, 1880. The patient stated that he had always enjoyed good health until eight years previously, when he contracted some venereal affection, which was followed by pains all over the body. He took iodide of potassium for a month, and was then able to resume his work; but since that time he had suffered every autumn and winter from a pustular eruption on the legs. With this exception his general health had been good, until a few months before his admission, when he began to suffer from occasional difficulty of breathing. The attacks of dyspnœa gradually increased in severity; a troublesome cough appeared; and finally the patient became unable to work, and applied for admission into the hospital. On admission, the man was in a very weak state, his chief complaint being of difficulty of breathing. Cough was troublesome; the belly was swollen; both legs were œdematous and covered with coppery stains, scaly patches, pustules, and ulcers, which were considered to be of a syphilitic nature. Several groups of lymphatic glands were enlarged. The cheeks, lips, and nose were blue; the great veins of the neck were prominent and turgid, while pulsation in the arteries was very weak. The skin of the trunk and neck had a mottled appearance, and the pulse was imperceptible at the wrist. The hands were cold. The heart's impulse was diffused, and pulsation was also visible in the epigastrium to the left of the sternal line. The exact situation of the apex-beat could not be defined, but the area of cardiac dulness was normal, the lowest limit being the fifth intercostal space. At the apex the first sound was obscure, and accompanied by a very faint blowing murmur. At the base, and in the second right intercostal space, the *bruit* was somewhat louder; but was much more distinctly heard in the epigastrium than elsewhere. The diastole was weak, but clear. The percussion sound was normal over the front of the chest; the posterior thoracic parietes were œdematous. The respiratory sounds were normal, except in a few places where slight mucous *râles* were audible. The area of dulness of the liver and spleen was somewhat increased. The urine was scanty, acid, specific gravity 1025, and contained traces of albumen. From these various signs, Dr. Federici diagnosed that the muscular structure of the right side of the heart was chiefly at fault, and that the disease was probably of a syphilitic nature. In spite of hypodermic injections of mercury, and large doses of iodide of potassium, the attacks of dyspnœa became more and more severe, especially at night; but the patient slept fairly well in a semi-erect position. The pulse was regular and about normal as regards frequency; but pulsation could never be felt in the radials, and even in the larger vessels, such as the femoral, was very weak indeed. The respiration was always accelerated (sometimes thirty per minute), and chiefly abdominal in character. The temperature was usually below normal. During the next few days the *bruit* gradually became fainter and fainter; but was always heard best at the epigastrium. The sputa became bloody, the dyspnœa more and more urgent, until, finally, the patient died rather suddenly, soon after a meal, nine days after his admission into the hospital. *Post mortem*, the pericardium contained about 3 ounces of clear serum. The heart was globular in form, and weighed nearly 14 ounces, the enlargement being due more to the left than the right ventricle. On the anterior surface of the right ventricle was a patch of fibrous induration, 8 centimetres long and 3 centimetres broad. On the left ventricle was a similar patch, of the size of a five-franc piece; and other smaller indurated patches were scattered over the surface. A hard fibrous cord, studded with nodules, followed the direction of the interventricular septum. All these parts were pale in colour, resisted the knife, and creaked on section. The tricuspid valve was healthy, with the exception of a slight enlargement on one of the cusps. The endocardium was opaque in patches. The left ventricle was considerably dilated, and the endocardium of the conus arteriosus was white, hard, and glistening, like cartilage. The musculi papillares of both ventricles were pale and shrunken. Under the microscope, the affected portions of the muscular substance showed the usual appearances of syphilitic myositis. The lungs were adherent in some places, emphysematous in others, and contained numerous infarcts. The liver showed a patch of syphilitic interstitial hepatitis in an early stage. The spleen was enlarged and rather hard, its capsule being opaque and partially adherent to the thoracic wall. The kidneys were much congested. The other organs of the body, as well as the larger bloodvessels, were healthy.—*London Med. Record*, June 15, 1882.

Tuberculosis of the Thoracic Duct.

The larger lymphatic vessels obtain far less attention at the present day from pathological anatomists than they received a hundred years ago. This is doubtless in part due to changes in current theories of disease, which ascribe to the lymphatics a smaller share in pathological processes than did the doctrines of an earlier day. Of late attention has been to a considerable extent diverted from the larger trunks to the minute lymphatic vessels. A few years ago, however, some observations by Ponfick on tuberculosis of the thoracic duct directed the notice of pathologists to one part of the subject, and some interesting observations on the same lesion have been published in a recent number of Virchow's *Archiv*,